Ashgate Manor

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Summary of findings

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Summary of findings

Overall summary

Derbyshire Health United provides out-of-hours General Practitioner (GP) services for more than one million patients living across Derbyshire. It is registered with the Care Quality Commission to provide the regulated activities of transport services, triage and medical advice provided remotely and the treatment of disease, disorder and injury.

We carried out the inspection as part of our new inspection programme to test our approach going forward. It took place over two days with a team that included two CQC inspectors, a GP, a GP practice manager, a nurse and an expert-by-experience.

We found the service was effective in meeting patient needs and had taken positive steps to ensure people who may have difficulty in accessing services were enabled to do so. There was an effective system to ensure that patient information was promptly shared with each patient's own GP to ensure continuity of care.

The provider had in place an innovative care planning system called 'Rightcare' that enabled seamless patient care during out-of-hours. The scheme was designed with patients with long term conditions and complex health needs including end of life patients in mind.

Patients told us that they were happy with the care and treatment they received and felt safe. There were robust systems in place to help ensure patient safety through learning from incidents, the safe management of medicines and good infection prevention and control.

The provider had taken robust steps to ensure that all staff underwent a thorough and rigorous recruitment and induction process to help ensure their suitability to care for patients.

Patients experienced care that was delivered by dedicated and caring staff. Patients and carers we spoke with said staff displayed a kind and caring attitude and we observed patients being treated with respect and kindness whilst their dignity and confidentiality was maintained.

We found that the service was well-led and managed by an enthusiastic and knowledgeable senior management team and board of directors, and their values and behaviours were shared by staff. Members of the staff team we spoke with all held very positive views of the management and leadership and felt well supported in their roles. They told us the senior managers were approachable and listened to any concerns or suggestions they might have to improve the level of service provision.

The leadership was proactive is taking steps to help ensure that GP's were supported in maintaining insurance indemnity at affordable levels and in promoting and facilitating career long learning for nurses.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found that the provider had in place robust and rigorous systems to ensure that people seeking to work at DHU were appropriately recruited and vetted to ensure their eligibility and suitability.

There were clear procedures and policies that staff were aware of to enable them to recognise and act upon any serious events or incidents and any learning was shared with staff. The provider had good systems in place to safeguard patients at risk of harm.

We found there were systems in place to help protect people from the risks associated with the management of medicines and infection control.

Vehicles used to take clinicians to patients' homes for consultation were well maintained, cleaned and contained appropriate emergency medical equipment. Emergency equipment held at the treatment centre was well maintained and serviced.

Are services effective?

We found that the service was providing effective care to a wide range of patient groups with differing levels of need often with limited information available to clinicians.

Clinicians were able to prioritise patients and make the best use of resources.

Clinicians had been subject to continuing clinical audit and supervision to ensure their effectiveness in delivering good quality care and treatment.

There was an effective system in place to ensure information about patients registered with a practice covered by DHU service was shared with their own GP at the earliest opportunity.

There was good collaborative working between the provider and other healthcare and social care agencies to help ensure patients received the best outcomes in the shortest possible time, for example by use of the care planning system called 'Rightcare'.

Are services caring?

Patients, their relatives and carers were all positive about their experience and said they found the staff friendly, caring and responded to their needs. We observed examples of good interaction between patients and staff and noted that staff treated patients with respect and kindness and protected their dignity and confidentiality.

We saw that staff obtained patient's consent and explained their treatment in a manner that reflected the patient's level of understanding.

Patient experience surveys conducted by the provider showed a high degree of satisfaction with the service provided and the attitude of staff towards patients.

There was a good process in place to ensure patients whose first language was not English, were able to access the service through interpreter services and the provider was taking positive steps to engage with and involve, hard to reach groups of patients.

Are services responsive to people's needs?

We found that the provider had an effective system to ensure that, where needed, clinicians could provide a consultation in patients' homes.

Summary of findings

The provider had responded to the needs of people from a wide geographical area and provided a choice of treatment centres for patients to maximise accessibility.

The was a complaints system and we saw that any learning from those complaints was shared with staff, although we noted that the procedures for making a complaint could be made more visible at the Ashgate treatment centre. One of the patients we spoke with said they would not know how to raise a complaint other than by looking on the DHU website.

The provider undertook continuing engagement with patients to gather feedback on the quality of the service provided.

There was good collaborative working between the provider and other healthcare and social care agencies to help ensure patients received the best outcomes in the shortest possible time.

Are services well-led?

Members of staff we spoke with talked positively about the management of the service and said there was a desire from above for staff to continually learn and improve.

There was a strong and stable management structure; the Chief Executive Officer, the nominated individual, registered manager and other senior staff were very knowledgeable and were an integral part of the staff team. The Board were very experienced and had diverse professional backgrounds and knowledge. Both the Board and executive displayed high values aimed at improving the service and patient experience and were taking positive steps to remind and re-enforce those values with all staff.

There was an emphasis of management seeking to learn from stakeholders, in particular through patient engagement groups.

There was a clear leadership and management structure and staff that we spoke with were clear in whom they could approach with any concerns they might have. We saw that staff underwent an annual appraisal and reflective supervision to enable them, amongst other things, to reflect upon their own performance with the aim of learning and improving the service.

The provider supported both clinical and non-clinical staff by providing a range of training opportunities all aimed at delivering high quality, safe care and treatment to patients

Staff told us that they worked for a supportive and progressive organisation.

Summary of findings

What people who use the out-of-hours service say

Patients who used the service, their relatives and carers told us that it met their healthcare needs and that both clinical and non-clinical staff treated them with respect, discussed their treatment choices and helped them to maintain their privacy and dignity.

They said they had not experienced difficulty accessing the service.

The patients and carers we spoke with during our inspection made positive comments about the quality of the service and the little time it had taken to see a clinician.

Two comments cards that had been left by the CQC were returned to enable patients to record their views on the service. They were positive and emphasised the caring and respectful attitudes of staff and excellent standards of care.

Good practice

Our inspection team highlighted the following areas of good practice:

We considered that the 'Rightcare' care planning tool was an innovative, leading edge service that had a positive impact on the lives of patients who had been involved in the scheme and ensured that patients were directed to the correct healthcare professional for their particular needs. Having access to care plans in the out-of-hours healthcare environment helped ensure that clinicians were in possession of relevant information appropriate to patients' needs.

The establishment of GP Chambers to help mitigate the increasing cost of out-of-hours insurance indemnity showed a positive approach to maintaining the safety of patients and the security of the out-of-hours GP service provision.

DHU had worked with Derby University on 'Life', a web based learning academy that provided competency based assessment and continuous professional development for staff.

There were good systems in place to ensure that the records were sent to the patient's own GP by the time the surgery opened the next day. For those patients who were not registered with a GP practice in the area covered by DHU, there was a process in place to ensure that the information was passed to their GP in a timely manner.

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Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP. The team included an additional CQC Inspector, a GP practice manager, a nurse and an expert-by-experience who helped us to capture the experiences of patients who used the service.

Background to Ashgate Manor

Derbyshire Health United (DHU) is a 'not-for-profit' social enterprise organisation. It held contracts to deliver NHS out-of-hours services on behalf the North Derbyshire, South Derbyshire, Hardwick and Erewash Clinical Commissioning Groups. The contract was an 'integrated' contract, meaning that it combined the NHS 111 telephone system and the delivery of out-of-hours GP services. The NHS 111 system is not a service that is required to be registered with the Care Quality Commission and as a consequence that part of the service was omitted from the inspection process.

DHU provided an out-of-hours GP service for over one million people living within Derbyshire. The service's principle operating base was at Ashgate Manor, Chesterfield that consisted of a call handling centre but also incorporated a primary care centre. Patients could be offered a consultation with a clinician there, or at 13 other satellite locations, dependent upon the day. On the day of our inspection patients could be treated at Ashgate Manor, Chesterfield Royal Hospital, Derby walk-in centre, Buxton Cottage Hospital, Ilkeston Community Hospital, Swadlincote Clinic and North High Peak. As part of our inspection we visited the primary treatment centres at Ashgate Manor and Chesterfield Royal Hospital.

The out-of-hours service operated whenever GP surgeries were closed. This was weekdays between 18:30hrs and 08:00hrs, and 24 hours a day at weekends and public holidays.

Calls from patients to their GP during out-of-hours periods were directed to NHS 111 telephone call handlers, who referred callers where necessary to clinical staff. In the 12 months February 2013 to February 2014 clinicians carried out more than 26,000 consultations in people homes, 89,000 consultations at primary care centres and offered clinical advice over the telephone on more than 69,000 occasions.

At the time of our inspection, DHU engaged the services of approximately 180 GP's who were engaged on a sessional basis. DHU also employed five GP's.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Detailed findings

Before visiting, we reviewed a range of information we held about the out-of-hours service and asked other organisations to share what they knew about the service. We also reviewed information that we had requested from the provider.

We carried out an announced visit to Ashgate Manor on 26 February 2014. During our visit we spoke with members of the staff team including the clinical director, medical director, DHU Vice Chair, nominated individual, director of nursing, registered manager, nurses, general practitioners, and those staff that dealt directly with patients, either by telephone or face to face. We also visited Chesterfield Royal Hospital and spoke with GP and nurse practitioner who were working there.

On 27 February we spoke with the Chief Executive Officer, board members and administration staff.

We spoke with five patients and carers who used the service. We observed how people were being cared for and talked with carers and family members. We reviewed two comment cards where patients and members of the public shared their views and experiences of the service.

We reviewed information that had been provided to us by the provider and other information that was available in the public domain.

We conducted a tour of two treatment centres and looked at the vehicles used to transport clinicians to consultations in patients' homes.

Are services safe?

Summary of findings

We found that the provider had in place robust and rigorous systems to ensure that people seeking to work at DHU were appropriately recruited and vetted to ensure their eligibility and suitability.

There were clear procedures and policies that staff were aware of to enable them to recognise and act upon any serious events or incidents and any learning was shared with staff. The provider had good systems in place to safeguard patients at risk of harm.

We found there were systems in place to help protect people from the risks associated with the management of medicines and infection control.

Vehicles used to take clinicians to patients' homes for consultation were well maintained, cleaned and contained appropriate emergency medical equipment. Emergency equipment held at the treatment centre was well maintained and serviced.

Our findings

We spoke with five patients and carers during the course of our inspection. None had any concerns about patient safety.

We saw that the provider had a robust and rigorous procedure for recruiting staff. Thorough checks were undertaken of GP's to ensure their fitness to practice for example General Medical Council registration and inclusion on the performers list. Suitable and verifiable references were sought and obtained. A GP we spoke with told us that the recruitment process was very thorough and included clinical scenarios that they had to successfully complete.

We saw all GP's were required to produce indemnity insurance that included out-of-hours cover and we looked at records that showed that such indemnity insurance was in place.

There was a rigorous clinical audit and appraisal process for GP's and other clinicians aimed at identifying and addressing any clinical issues. An advanced nurse practitioner told us that DHU conducted supervision of all nurses, aimed at supporting staff, enhancing knowledge and encouraging reflective practice and continuous improvement.

All staff were subject to checks to ensure their suitability to work with vulnerable people. We saw that there was a thorough induction process that enabled staff to be assessed as competent in areas relevant to their work. We were provided with a copy of the induction program and we talked with an advanced nurse practitioner and trainer who explained in detail how the induction process worked and how they observed staff's practice to assess their competence.

The service operated a chaperone policy to enable patients to be accompanied during a consultation and we saw that drivers who took clinicians to patients' homes had undertaken chaperone training.

There was a process in place to ensure that clinical staff continued to be registered with their appropriate professional body, be it the Nursing and Midwifery Council or General Medical Council.

We saw the treatment centres were accessible to people with restricted mobility such as wheelchair users and that patient accessible areas were in very good condition.

We looked at the vehicles used to take doctors to consultations in patients' homes and saw that they were in good condition and regularly maintained. We looked at the equipment carried in the vehicles that could be used by a GP in the event of a medical emergency and found it to be appropriate, well maintained and checked regularly.

We found there were appropriate arrangements in place to provide medicines when required, for example when community pharmacies were closed. The amount of medicines stored was closely monitored and controlled and we saw evidence that they were regularly checked to ensure they had not exceeded the expiry date recommended by the manufacturers to ensure their effectiveness. The temperature of fridges used to store medicines was regularly monitored. A medicines management policy was in place as were procedures for ensuring the formulary was in line with national and local guidelines. Drugs and medicines were kept securely.

Are services safe?

We observed that all areas of the treatment centre were visibly clean and there were no discernable odours. The patient waiting area at Ashgate Manor was clean, bright and well lit.

Hand sanitising liquids were freely available and we saw posters were displayed promoting good hand hygiene. Plentiful supplies of aprons and disposable gloves were available in wall mounted dispensers. There were appropriate procedures in place to protect patients and staff from the dangers associated with the disposal of sharps.

Staff told us and records showed that staff received instruction and training in infection control. We saw evidence of both internal and external audits in infection prevention and control aimed at helping to highlight any area of concern or areas for improvement.

We saw that the provider had a safeguarding policy and found that it was freely available to staff on the computer system. All staff received instruction and training in safeguarding vulnerable people. Staff spoke knowledgeably about safeguarding children and vulnerable adults and were able to explain in detail the action they would take had they any concerns. There was a 'whistle blowing 'policy in place and staff that we spoke with were familiar with it.

Are services effective?

(for example, treatment is effective)

Summary of findings

We found that the service was providing effective care to a wide range of patient groups with differing levels of need often with limited information available to clinicians.

Clinicians were able to prioritise patients and make the best use of resources.

Clinicians had been subject to continuing clinical audit and supervision to ensure their effectiveness in delivering good quality care and treatment.

There was an effective system in place to ensure information about patients registered with a practice covered by DHU service was shared with their own GP at the earliest opportunity.

There was good collaborative working between the provider and other healthcare and social care agencies to help ensure patients received the best outcomes in the shortest possible time, for example by use of the care planning system called 'Rightcare'.

Our findings

DHU operated a rigorous clinical audit system to continually improve the service and deliver the best possible outcomes for patients. The organisation had a Clinical Governance Committee that reviewed incidents and rated them to determine the level of risk from each one. This enabled the team to determine the action required in response. Concerns were discussed at a performance group and where appropriate clinicians had been provided with support to help them improve. The Clinical Audit Committee also fed back to the Clinical Governance Committee on the results of its audits into areas such as safeguarding adults, appropriateness of home visit requests and medicine management. We judged that the clinical audit system was robust and effective in ensuring that patients continued to receive effective, high quality care and treatment.

The service fostered a close working relationship with other healthcare and social care providers such as social services, the mental health crisis team and district nursing out-of-hours team. Close collaboration between agencies helped to ensure that patients were given the best opportunity to experience 'joined up' health and social care, for example we saw that DHU had pioneered a system called 'Rightcare' which was aimed at ensuring patients received seamless care out-of-hours when their own GP surgery is closed. Rightcare was designed with patients with long term conditions and complex healthcare, including end of life patients in mind, and was aimed at preventing unnecessary admissions to hospital and attendance at Accident and Emergency departments. It aimed to lower patient anxiety, provide re-assurance and allow patients quick access to the most appropriate healthcare. It consisted of thorough care planning undertaken by the patient, GP and other healthcare professionals which was shared with DHU and was available to clinicians until such time as the patient no longer required the plan. A copy of the care plan was given to the patient to help them to decide when medical help was needed. They were also given a telephone number to allow them to contact DHU without the need to use the NHS 111 system. We saw that there were currently 7,000 patients using Rightcare and GP's were being encouraged to raise this number to around 8,000. All of the staff and clinicians we spoke with were clear that Rightcare had positive benefits for patients and reduced the load on services such as Accident and Emergency Departments.

There are National Quality Requirements (NQR's) for out-of-hours providers that capture data and provide a measure to demonstrate that the service is safe, clinically effective and responsive. The service is required to report on these regularly. We saw evidence that DHU had been fully or partially compliant and where there had been room for improvement they had been identified and steps taken to improve performance.

We viewed the quality report for the October-December 2013 and saw that it reported on a wide range of quality indicators including prescribing, pathway assessments, complaints, significant events and serious incidents. Any learning from these indicators was communicated to staff to help increase the effectiveness of the service.

Following a patient consultation, all clinicians were responsible for completing patient notes. We saw that these were comprehensive and informative. There were good systems in place to ensure that the records were sent to the patient's own GP by the time the surgery opened the

Are services effective?

(for example, treatment is effective)

next day. For those patients who were not registered with a GP practice in the area covered by DHU, there was a process in place to ensure that the information was passed to their GP in a timely manner.

All patients, when they received a consultation at their home were given a copy of the summary of the clinical consultation.

Responses from patient surveys showed a very high level of satisfaction in the service and standard of care and treatment provided by DHU.

Are services caring?

Summary of findings

Patients, their relatives and carers were all positive about their experience and said they found the staff friendly, caring and responded to their needs. We observed examples of good interaction between patients and staff and noted that staff treated patients with respect and kindness and protected their dignity and confidentiality.

We saw that staff obtained patient's consent and explained their treatment in a manner that reflected the patient's level of understanding.

Patient experience surveys conducted by the provider showed a high degree of satisfaction with the service provided and the attitude of staff towards patients.

There was a good process in place to ensure patients whose first language was not English were able to access the service through interpreter services and the provider was taking positive steps to engage with and involve hard to reach groups of patients.

Our findings

We spoke with five people who were waiting to be seen by the clinicians or were accompanying children or relatives. They were complimentary about the service and in particular praised the caring and friendly nature of staff. Their comments included;

"The nurse told us what was going to happen and talked with (my child) which put them at ease." Another said, "Staff were great at making me feel calm."

During the course of our inspection we observed the interactions between patients and carers and DHU staff. Without exception we saw that staff acted in a kind and sympathetic manner and maintained the patient's dignity and confidentiality at all times.

We saw that the patient waiting area was warm and comfortable with adequate seating. Some health promotion and information material was available.

We noted that the seating in the patient waiting area was arranged as to allow staff in the reception area to see patients' front aspect. This helped staff to recognise if a patient who was waiting for a consultation had suffered deterioration in their condition that might require an earlier intervention from clinicians.

We observed a nurse talking with a child and parent who were waiting to be seen by a clinician about what was happening. We heard how the nurse communicated with the child at a level they could understand.

We were provided with evidence to show that the service was taking steps to try and reach groups of patients that have traditionally proved difficult to reach, for example young males, mothers with young children, people with mental health issues, people with learning disabilities and people whose first language was not English. We saw how literature had been produced in four languages and we saw evidence of the planned use of social media such as 'Facebook' and 'Twitter' in reaching these groups and others.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

We found that the provider had an effective system to ensure that, where needed, clinicians could provide a consultation in patients' homes.

The provider had responded to the needs of people from a wide geographical area and provided a choice of treatment centres for patients to maximise accessibility.

The was a transparent complaints system and we saw that any learning from those complaints was shared with staff, although we noted that the procedures for making a complaint could be made more visible at the Ashgate treatment centre and one of the patients we spoke with said they would not know how to raise a complaint other than by looking on the DHU website.

The provider undertook continuing engagement with patients to gather feedback on the quality of the service provided.

There was good collaborative working between the provider and other healthcare and social care agencies to help ensure patients received the best outcomes in the shortest possible time.

Our findings

Patients we talked with comments included;

"It was only one call and I was in. I had no problems finding the place; the woman on the phone gave me great directions."

"You're always seen quickly."

"I rang at 9:30 and given an appointment for 11:00. I came early because my child's breathing was getting worse. Because of this I was sent straight through, which was great."

We looked at the National Quality Requirements (NQRs) for out-of-hours GP services, and found that where there had not been full compliance, we saw that supplementary reports had been produced that highlighted areas for improvement.

The service had in place clear procedures for ensuring that patients who had difficulties in communicating, for example as a result of their first language not being English, were able to access the service and understand throughout their contact with DHU. Staff were familiar with the telephone translation service available. We saw how a patient whose preferred language was Punjabi was put in contact with an interpreter to allow them to access the service.

We looked at the staffing levels at the primary treatment centres and them to be sufficient to meet the needs of the patients. We looked at the numbers of patients who used the service and found that the numbers were not subject to high rates of fluctuation which made it possible for staffing levels to be accurately assessed and managed. Additional staff were available to meet increased demand, without needing to resort to locum staff, although one GP was 'on call' to respond immediately to increasing demands on the out-of-hours service.

We saw evidence that the service had responded quickly to manage the risk posed from an outbreak of meningitis at local nursery and arranged an immunisation program for those at risk. The provider temporarily closed one of their primary treatment centres and arranged consultations for out-of-hours patients at an alternative location to enable the immunisation to program to go ahead.

There was a transparent complaints system that showed that any complaints that had been received about the service had been responded to in an appropriate manner and patients were kept informed of the progress and result of any subsequent investigation. There was evidence that any learning from those complaints and other incidents was used to improve the service. We saw that the level of complaints was low, amounting to 0.086% of patient contacts with the service.

We saw evidence that DHU conducted ongoing patient experience questionnaires, and used the 'Friends and Family' test to help them assess the quality of service provision. We saw that they responded to any concerns or issues that had been identified.

The patient newsletter had been re-designed as a result of the involvement and advice of the patient and public involvement group

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

Members of staff we spoke with spoke positively about the management of the service and said there was a desire from above for staff to continually learn and improve.

There was a strong and stable management structure; the Chief Executive Officer, the nominated individual, registered manager and other senior staff were very knowledgeable and were an integral part of the staff team. The Board were very experienced and had diverse professional backgrounds and knowledge. Both the Board and executive displayed high values aimed at improving the service and patient experience and were taking positive steps to remind and re-enforce those values with all staff.

There was an emphasis of management seeking to learn from stakeholders, in particular through patient engagement groups.

There was a clear leadership and management structure and staff that we spoke with were clear in whom they could approach with any concerns they might have. We saw that staff underwent an annual appraisal and reflective supervision to enable them, amongst other things, to reflect upon their own performance with the aim of learning and improving the service.

The provider supported both clinical and non-clinical staff by providing a range of training opportunities all aimed at delivering high quality, safe care and treatment to patients

Staff told us that they worked for a supportive and progressive organisation.

Our findings

There was a clear focus on clinical excellence and a desire to achieve the best possible outcomes for people, whether that was achieved from the patient contact with DHU or through referral to another healthcare or social care provider.

The service operated an 'open culture' and actively sought feedback and engagement from staff all aimed at maintaining and improving the service.

DHU had a wide range of quality assurance processes in place to continually monitor and assess the quality of service provision which included a range of audits to help identify and instigate actions to address any shortfalls.

We saw that there was comprehensive range of training available to staff. The provider had invested in providing this training in a face- to-face format, rather than rely upon e-learning.Training was conducted in staff's contracted hours, or where this was not possible they were paid for their time to complete it.

DHU was working with Derby University to establish 'Life', a web based learning academy, and providing competency based assessment and continuous professional development.

Staff that we spoke with, and records we saw confirmed, that the provider undertook an annual appraisal with staff to enable them, amongst other things, to reflect upon their own performance with the aim of learning and improving the service. Members of staff told us that they received reflective supervision that enabled them to talk about distressing or difficult issues they had encountered, encouraged open support, contributed to learning and development and promoted safe and effective patient centred practise.

There was a clear commitment to learn from problems, complaints and incidents and DHU demonstrated an open approach to these issues. We saw all staff were encouraged to report any concerns or incidents through either the 'datix' system or the daily shift reports that were monitored to pick up any concerns or items for further action. The provider demonstrated an open approach to these issues and informed staff of any learning from them through the weekly newsletter.

We saw that the Board had identified that the increase in the insurance indemnity fees payable by GP's when practising in out-of-hours posed a considerable threat to the viability of out-of-hours services. The Board was seeking to set up a GP Chambers, which would enable indemnity insurance to be obtained at considerably lower levels. This shows that the Board showed good leadership and vision.